

An Assessment of Health Coverage Industry Trends and CareFirst's Strategic Response

This paper summarizes our assessment of trends in the Health Coverage industry, and local trends affecting CareFirst and the Mid-Atlantic region. It also assesses one strategic alternative available to CareFirst, including its impact on constituents.

An objective of this assessment is to understand how key constituent groups – such as consumers, communities, employers, providers and hospitals, and brokers – have fared when a local Blue Cross Blue Shield plan goes through changes in its corporate form. We looked at two examples:

- Blue Cross of California and its conversion to for-profit status (the overall health plan now goes by WellPoint Health Networks; however, products in California are still sold under the name Blue Cross of California), which took place in 1993
- Blue Cross Blue Shield of Connecticut, who was acquired by Anthem Blue Cross Blue Shield in 1998, which subsequently converted to for-profit status

To assess these examples, we conducted interviews, surveys, and focus groups to collect constituent feedback. We also interviewed executives from each health plan and conducted secondary research from state Departments of Insurance and SEC filings, media, and industry analyst reports.

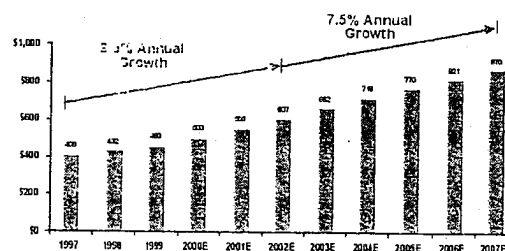
Health plans are being squeezed - rising healthcare costs, state and federal mandates, changing technologies, and increasing customer expectations have nar-

rowed health plan margins, while simultaneously accelerating investment in their base business.

According to government estimates, from 1997 through forecasts for 2002, private healthcare costs have been increasing nationally at an average rate of 8.3%. This trend of rapidly rising healthcare costs is expected to continue over the next few years.

National Health Care Cost Increases Continue

Private Healthcare Expenditures
(Excluding Research & Construction, \$ in Billions)



Source: Centers for Medicare & Medicaid Services (formerly Health Care Financing Administration), Historical Health Care Expenditure Projections, 1999-2002, May 2001

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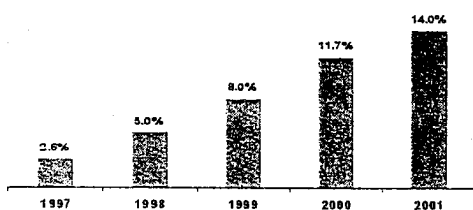
The dramatic rise in healthcare costs has forced many companies to reduce medical benefit offerings and to shift more of the payment burden to employees. Some health plans are exiting federally funded programs as costs increase without corresponding increases in federal funding. Based on filings with the Centers for Medicare and Medicaid Services (CMS), over 900,000 Medicare members needed to enroll with a different health plan in 2001 because health plans chose not to renew their Medicare+Choice contracts, or reduced the geographies they cover.

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As a result of cost increases, health plans have been forced to increase premium rates significantly since 1996, with double-digit increases nationally over the past two years.

Premiums Increase In Response to Increased Health Care Costs

HMO/POS Rates, % Increase In Average Per Employee Premium
(Fully Insured Plans Only)



Source: Chart & Data First Boston, Benefit Manager Survey, January 30, 2001

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To mitigate rising costs, and to respond to innovations and increasing consumer sophistication, health plans are responding by making a series of investments. We estimate the combined cost of these investments for large health plans range from \$420 - \$640 million, and possibly more, over the next five years. Some of these investments include:

- **HIPAA** – Large health plans are expected to invest \$30 - \$60 million, on average, over the next several years to comply with HIPAA (in May, 2001, Gartner Group estimated HIPAA costs to be 1 to 2 times health plans' average Y2K expenditures).
- **eCommerce** – Many large health plans are spending \$10 - \$40 million over several years to acquire and implement new eCommerce technologies, which promise easier service and streamlined operations for members, providers and others. Overall eCommerce investments for larger health plans could be significantly greater.
- **Consumer-focused Initiatives** – One way to mitigate the rise in healthcare costs, and for health plans to become more customer friendly, is to implement

services and products that increase consumer choice and flexibility. Some larger plans will invest as much as \$20 - \$40 million implementing such consumer-focused products and services.

- **Improvements to Operational Systems, Processes and Assets** – Rising healthcare costs have forced health plans to significantly upgrade their basic operations (e.g., computers, communications, software programs, processes, operating procedures, manuals, training, office space, staffing). In fact, many health plans have projects underway to replace and/or consolidate their basic operating systems. On average, plans are spending \$30 - \$50 million for investments to improve operational systems, processes and assets. Health plans will have an increasing need to modify their businesses to adapt to changes in the market place
- **Participating in Mergers and Acquisitions** – Industry consolidation is affecting nearly all health plans. Many are involved in some type of consolidation activity. We estimate the mergers and acquisitions cash need to be in the range of \$330-\$450 million. This is based on a review of actual transactions already completed. Specifically, we looked at the average actual cash expended by large health plans for mid-range acquisitions since 1997. We then screened this figure against available merger candidates in CareFirst's home market area to ensure consistency.

Health Plans' Investment Needs Will Be Substantial

Estimated Average Health Plan Investment Needs in the Next 3-5 Years*
(for Large Health Plans with Revenues > \$500 Million)

Investment Category	Low	High
HIPAA Health Insurance Portability and Accountability Act	\$30	\$60
eCommerce	\$10	\$40
Consumer-focused initiatives	\$20	\$40
IT Infrastructure Improvements	\$30	\$50
Merger and Acquisition Activity**	\$330	\$450
Other (e.g. merger integration expenditures, partnerships, interconnectivity, potential future regulations, etc.)	Additional	Additional
Total Investment (in Millions)	\$420+	\$640+

* Estimates based on industry analysis projections and current market conditions, may evolve given new information over time

** Estimated based on the average actual cash expended on mid-range health plan acquisitions since 1997, screened against available merger candidates in CareFirst's markets

Source: Gartner Research, 2000 PowerIT Budget and Staffing Survey, August 14, 2001; Gartner Research, 2000 IT Spending and Staffing Survey, October 2, 2000; SEC Filings; Company press releases; Merger news articles; Accenture analysis, surveys and client experience

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To further complicate the financial picture, the National Association of Insurance Commissioners (NAIC) has put in place a more rigorous methodology for calculating risk-based capital levels. As a result, reserve requirements for health plans have increased, thereby restricting the use of health plans' existing capital. As noted in a report last spring by Conning & Company, a leading firm that monitors trends and activity in the insurance industry:

"The attention to health plans' capital levels, stimulated by an NAIC-led effort to develop a consistent, rigorous national methodology for calculating plans' capital adequacy, has put many nonprofit plans in awkward position... These new, mostly higher expectations for capital adequacy, we believe, have led to a tendency among the nonprofit Blues plans to hoard capital, even though the competitive environment usually rewards ongoing capital investments in areas like computer technology. The concern is that, without access to the capital markets to raise additional capital, many plans may be hoarding capital and under-investing in new technologies and in other strategic areas."

Two popular techniques health plans are using to fight the squeeze include expansion to gain scale economies, and accessing the public equity markets. These strategies can make operations more efficient, and better enable health plans to make the significant investments described earlier in this paper. Combined, these actions could put health plans on a "virtuous cycle" for ongoing growth.

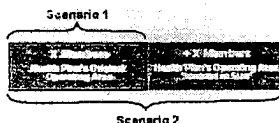
Increasing a health plan's member base can drive scale economies—expenditures can be spread across more members, and more funds are generated to make the investments described above. Increased scale can also help stabilize earnings, enabling health plans to withstand downturns in individual segments of their businesses.

- Anthem Blue Cross Blue Shield of Connecticut has saved millions of dollars due to economies of scale, reducing its administrative cost ratio from 21% to 13% in three years. To achieve this improvement, Anthem has made many changes to its business. Some of the cost reductions include:
 - Materials and services procurement costs - \$2.5 million in annual expenditures was saved by negotiating broader contracts for copiers and paper; other supplier contracts yielded similar benefits
 - Data center costs – Over \$10 million annually has been saved through management of data center costs across the Anthem organization
 - Transaction outsourcing – Approximately \$5 million in annual costs have been saved by negotiating better discounts for outsourced transaction processing based on higher business volumes
- From the WellPoint Health Networks' (parent company of Blue Cross of California) 2000 Annual Report: "The administrative expense ratio decreased to 14.0% for the year ended December 31, 2000 from 14.7% for the year ended December 31, 1999 [added note: down from 16.3% in '94]. The overall decline is primarily attributable to savings from the integration of information systems centers related to acquired businesses on the Company's information systems platform, a reduction in Year 2000 remediation expense from 1999 levels, economies of scale associated with premium revenue growth in relation to fixed corporate administrative expenses in addition to technology investments made by the Company (e.g., electronic claims submission, internet self-service and interactive voice response)."
 - A WellPoint Senior Vice President estimated that due to WellPoint's consolidation of system platforms, WellPoint could realize savings in HIPAA expenditures of \$30 – \$50 million per plan.
- A major Blue Cross Blue Shield plan (with more than 6 million members) – realized economies of scale after systems were consolidated. It reduced process-

ing costs by 25% per claim transaction and 25% per customer service transaction.

Increased scale can also help stabilize a health plan's earnings, since a larger base of business enables a plan to better withstand downturns in individual segments of its business.

How Increasing Scale Stabilizes Income



ILLUSTRATIVE

Scenario 1
A health plan earns a 2.0% profit margin on \$200M in revenue. The plan makes \$4M in net income.

A health plan's margin decreases by 50% to a 1.5% profit margin on \$300M in revenue. The plan makes 50% less in net income.

Scenario 2
A health plan's margin decreases by 50% to a 1.5% profit margin. However, if the plan is able to double its member base, it will earn \$4.5M in net income.

Revenue	\$200M
Operating Margin	X 2.0%
Net Income	\$4.0M

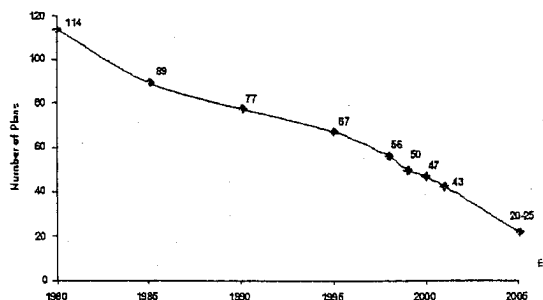
Revenue	\$300M
Operating Margin	X 1.5%
Net Income	\$4.5M

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Many plans have gained scale by acquiring other, generally smaller, health plans. This is evidenced by the large number of health plan combinations over the past 10 years, and the unprecedented reduction in the number of Blue Cross Blue Shield plans – from 114 to 43 – over the past 20 years.

Blue Cross Blue Shield Consolidation

Number of Blue Cross and/or Blue Shield Plans by Year

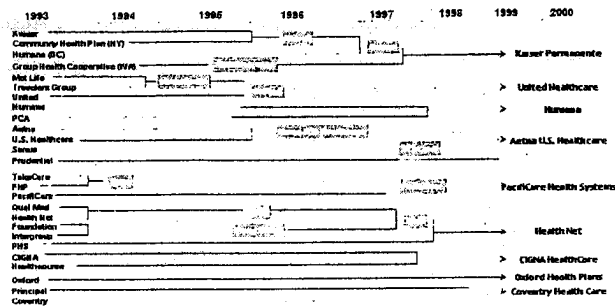


Sources: Consulting & Company, The Blue Cross and Blue Shield Plans: Past, Present and Future, 2002; BCBSA Press for the Year: 1980, 1985, 1990 and 2001

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Health Plan Consolidation

Non-BCBS Health Plan Consolidation



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Health Plan Consolidation, cont.

Examples of Recent Non-BCBS Health Plan Merger Activity

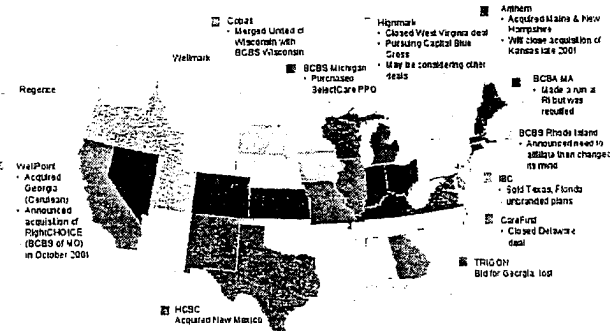
Year	Health Plan Activity
1999	<ul style="list-style-type: none"> Health Risk Management, Inc. completed its purchase of Oxford Health Plans of Pennsylvania, Inc. and renamed the plan HPM Health Plans, Inc. Health Net, Inc. (formerly Foundation Health Systems) sold its plans in Texas, Oklahoma and Louisiana to AmCareCo Inc., the parent company of AmCare Health Plans. Anthem U.S. Healthcare began offering an HMO and point-of-service plan in the Raleigh-Durham area North Carolina. Kaiser Permanente Northeast Division closes effective December 31, 1999 after operations in Connecticut, Massachusetts, New York, North Carolina and Vermont were all sold. HealthCare America Plans, Inc. (HCA) was acquired by Coventry Health Care of Kansas, Inc. - Wichita
2000	<ul style="list-style-type: none"> Harris Methodist Health Plan (TX) was acquired by PacificCare Health Systems United Healthcare sold the Pacific Northwest and transferred its members to Premier Blue Cross in Washington and Lifenet in Oregon. Coventry Health Care, Inc. completed its acquisition of Medicare Louisiana, Inc. Coventry Health Care, Inc. completed its acquisition of WellPoint Community Health Plans, the managed care subsidiary of Duke University Health System
2001	<ul style="list-style-type: none"> Group Health Plan (UQ), a subsidiary of Coventry Health Care, Inc., acquired the commercial membership of Health Plans of the Midwest. Coventry Health Care of Kansas, Inc. signed a definitive agreement to acquire Kaiser Foundation Health Plan of Kansas City

Sources: The Information Company's E&P; HMO Industry Report Vol. 1 & 11.1; Publications; Grouping in the HMO Industry, April 2000; August 2001

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Blue Cross Blue Shield Consolidation

Blues Consolidation



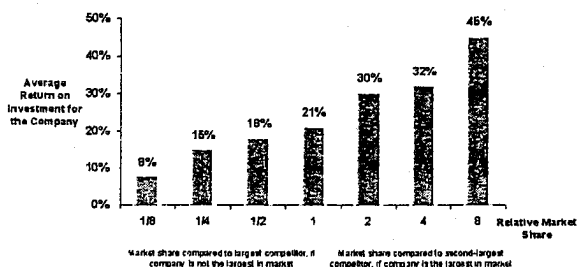
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When a health plan acquires another health plan that competes in the same market, there is potential for an additional advantage. Studies have shown that companies across industries perform better if they are able to maintain a strong market share relative to their competition (relative market share):

Cross-Industry Impact of Relative Market Share on Returns

Return on Investment versus Relative Market Share

(relative market share = market share of the company divided by the market of the largest or next largest company in market)



Source: Accenture Analysis, PIMS (Profit Impact of Market Strategy), based on 5000 strategic business units across a variety of industries

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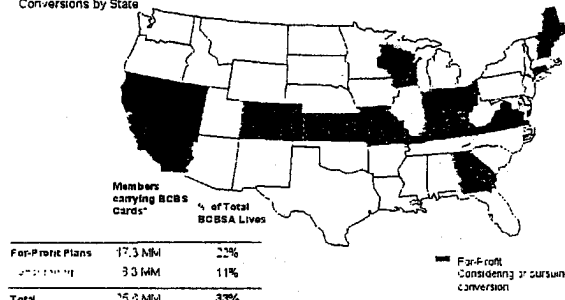
As the health insurance industry consolidates, this phenomenon also presents a threat to health plans' competitiveness. A health plan's relative market share diminishes as the health plans with which it directly competes (those in its current markets, as opposed to those in adjacent or remote markets) consolidate. If it wishes to protect its relative market share in home markets, a health plan needs to participate in the consolidation. It needs to act when local, direct competitor health plans come up for sale. Of course, doing so requires capital.

Some health plans are increasing access to capital by accessing public equity markets. A common way to do this is to convert from not-for-profit to for-profit status, and then raising funds through the public equity markets. There has been a wave of such conversions, primarily among Blue Cross Blue Shield plans, with more contemplated. About 79 million Americans carry Blue Cross Blue Shield cards. Approximately one third

of those are members of Blue Cross Blue Shield plans that are either for-profit plans or are considering a for-profit conversion.

Many Blue Cross Blue Shield Plans Converting to For-Profit

Blue Cross Blue Shield Plan Planned and Actual Conversions by State



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The objective for taking these actions is to establish a "virtuous cycle": increased scale and access to capital drives cost reduction and investment in service improvements. These, in turn, increase a plan's attractiveness to members and employers, which in turn attracts new customers, further increasing scale, and so on.

How Growth and Targeted Investments Can Build Off Each Other

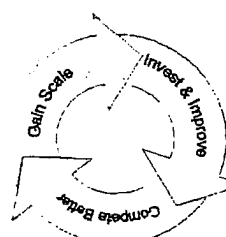
A "Virtuous Cycle" for Health Plans

Gain Scale

- Increase member base
- Increase revenues
- Position health plan for increased investment

Compete Better

- Use advantages to enhance competitive position, e.g.:
- Reduced rates, or lower rate increases due to lower operating costs
- Improved and/or differentiated services



Invest and Improve

- Exploit the advantages available through increased scale
- Reduce operating costs by aggressively pursuing economies of scale - e.g. integrating core systems and operations
- Invest more in innovative and/or differentiating services and products - e.g. e-commerce, consumer focused initiatives, improved operations

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These national trends are playing out in the Mid-Atlantic region, with rising healthcare costs, significant investment requirements, increased scale of competitors, for-profit conversion and small plans closing down or being acquired.

Each of these trends is affecting CareFirst specifically. For example, over the past three years, CareFirst experienced average annual healthcare cost increases of 7.8% in its Commercial HMO business, and 10.0% in its Maryland Small Group business.

Like other health plans, CareFirst is investing to improve service to customers and to comply with changing regulatory requirements. Because of limited access to capital, CareFirst has had to sequence new efforts, deferring, for example, some critical eCommerce initiatives (particularly provider and member self service initiatives).

The Mid-Atlantic region has seen consolidation as well: Coventry Health Care purchased all or parts of 11 health plans in a three-year period; Aetna acquired U.S. Healthcare, NYLCare, and Prudential Healthcare. Several smaller plans have gone out of business or been acquired, including the George Washington University Health Plan, Innovation Health, and the QualChoice of Virginia Health Plan. Blue Cross and Blue Shield of Virginia, now known as Trigon, converted to for-profit status and became a publicly traded company in 1997. CareFirst itself represents the affiliation of Blue Cross Blue Shield plans serving Maryland, the Washington D.C. region, and Delaware.

We believe that to maintain its competitiveness in the face of these industry pressures, CareFirst would benefit from a substantial increase in scale and capital access. One of the options available to CareFirst to do so quickly would be to combine with a large, for-profit health plan.

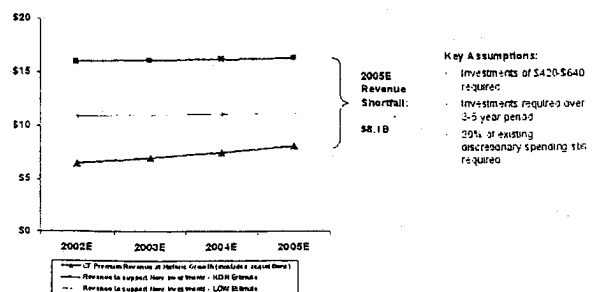
Accenture helped CareFirst estimate that a scale of \$11-\$16 billion in annual revenue could greatly aid it in maintaining competitiveness over the next several years. This range was estimated based on our assessment of CareFirst's capital needs, which includes:

- Making the strategic investments described earlier in this document, estimated to be \$90 - \$190 million over three to five years, and
- Funds for opportunistic acquisitions of smaller plans in the Mid-Atlantic region. Our examination of other transactions led us to estimate that a plan the size of CareFirst could spend as much as \$330-450 million in such transactions.

We used two methods to estimate a potential target revenue range for CareFirst. First, we analyzed CareFirst's recent income statements to assess how much income CareFirst has been able to devote to strategic/acquisition investments. We compared CareFirst's historical investment budgets with our estimate of investment needs in order to estimate the desired scale. Second, we examined the size and growth rates of CareFirst's competitors in the Mid-Atlantic region, and projected the size CareFirst would have to be in order to not lose ground (in terms of scale) relative to those competitors. The result of these two methods was an estimate of desired size for CareFirst of \$11-\$16 billion in annual revenue.

CareFirst's Projected Revenue to Support Investments

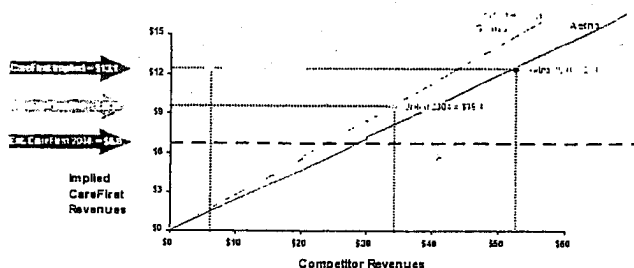
CareFirst Revenue Required to Support Investments
(\$ in Billions, 2002E - 2005E)



Source: CareFirst data, Accenture Analysis

CareFirst's "Implied" Revenue Compared with Competitors

CareFirst "Implied" Revenue to Maintain Size Relative to Competitors, 2004
(\$ in Billions)



Source: CareFirst data, SEC filings, Accenture analysis

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CareFirst Advantageous Size Target

Estimated Advantageous Target Size Range for CareFirst in 3-5 Years
(measured in billions of revenue dollars)

Estimation Method	Low	High
Investment Support Level	\$11.2	\$16.2
Scale Relative to Competitors	\$10.9	\$13.1
Estimated Revenue Target (in billions)	\$11	\$16

Source: CareFirst data, SEC filings, Accenture analysis

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This revenue scale would be very difficult for CareFirst to achieve through home-market expansion (i.e., through incremental growth). Just being able to support the strategic investments would require substantial market share expansion, adding as many as 1.4–3.1 million members to its 2000 year-end membership. Another option would be to expand beyond CareFirst's present boundaries; however, CareFirst's Blue Cross Blue Shield brand license limits CareFirst to competing with the Blue Cross Blue Shield brand in its current geographic markets. And, while less formal affiliations can provide some business and marketing benefits, they

generally limit the opportunities to achieve economies of scale compared with true mergers.

Although the affiliations CareFirst already has in place enable it to maintain a larger capital base, state-mandated CareFirst-specific regulations restrict the ease with which this capital can be deployed. Financial transactions and asset allocations greater than \$500,000 require affiliated CareFirst plans to provide written notification or to gain approval by state insurance regulators, a level of regulation greater than that faced by other health insurance companies in the region. As part of a change in corporate form, CareFirst might be able to work with regulators to be subject to the same regulations as its competition.

This approach to gaining scale could provide other benefits in addition to helping CareFirst better manage costs and access investment capital. Examples include:

- Diversifying CareFirst's business: combining with another health plan could provide CareFirst with a more diverse business (i.e., covering a more diverse set of geographies, with more diverse customer segments and employers), thus helping CareFirst maintain financial stability. During its acquisition of BCBS Maine, Anthem Blue Cross Blue Shield described how this strategy benefited both the plan and its customer base.

"Our focus on growth and financial strength is integral to our strategic plan to remain competitive. With size comes the ability to maximize efficiencies and to withstand regional economic swings. For example, Anthem's size and flexibility allowed our Kentucky subsidiary to stay in the individual market during that state's 1995-1998 experimentation with healthcare reform, a period during which all other commercial carriers exited the market while Anthem persevered and worked with governmental, consumer and industry representatives to produce necessary changes."

- Enhancing CareFirst's attractiveness to larger employers: Expanded scale could increase CareFirst's geographic coverage, making it more attractive to regional and national employers looking to use health plans that cover similar territories. Although Blue Cross Blue Shield plans currently cover the nation, each Blue's operation is distinct, limiting its ability to provide seamless coverage to larger employers compared to nationally consolidated plans).

Since CareFirst lacks sufficient capital to be an acquirer on the scale that it targets, the option described above would likely be structured as a simultaneous for-profit conversion and acquisition of CareFirst by another health plan.

Market forces appear to be driving Blue Cross and Blue Shield plans to pursue mergers and access to the public equity markets. As more and more health plans do so, plans that lack these advantages could find competing more difficult over time. Because such a move could make CareFirst a stronger company, and because CareFirst currently possesses a strong market position, the timing appears favorable for CareFirst to make such a change.

Industry analysts see the conversion of Blue Cross Blue Shield plans as not only wise, but necessary in some cases. Samuel Levitt, a leading analyst and author of a recent report by Conning & Company, says "...the economic realities of healthcare leave them no choice [but to convert to for-profit and access the public equity markets]...we think it's not in general a very friendly environment for non-for-profits." A. M. Best, which analyzes the health insurance industry and rates specific organizations, published an article last year that stated:

"The consolidation of Blue Cross & Blue Shield plans surged during the 1990s and will continue to sweep the insurance industry well into the next

century. Whether it be in response to the regulatory environment, a need for improved efficiencies or simply company survival, mergers and acquisitions have become a primary issue for most insurance companies." Later, the article states, "As consolidations continue and the need for access to capital increases, the conversions to for-profit status will rise symmetrically."

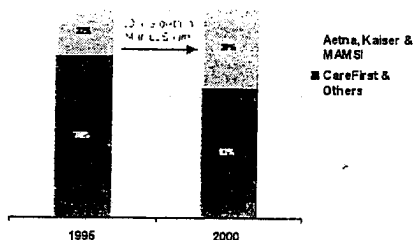
Investment bank Shattuck Hammond states in its Spring 2001 State of the HMO Industry report:

"In order to sustain earnings growth, national HMOs will return to the acquisition market. In addition, we believe that they will become more aggressive in their acquisition valuations" And later: "Rapid Blue Cross Blue Shield consolidation expected to continue...low profitability and limited access to capital have been the two primary factors driving the consolidation. The strong share price performance by the publicly traded Blue Cross Plans as well as additional Blue Cross Blue Shield IPOs and for-profit conversions should further facilitate the consolidation through increased access to capital and diminished geopolitical obstacles."

The timing appears favorable for CareFirst to make such a change because it is profitable and has built a strong market position. As a result, CareFirst could command an attractive price from a prospective buyer. In the past four years, the combined market share of CareFirst's three largest competitors in the region increased from 22% to 37%. Should CareFirst's competitors continue their recent improvements, CareFirst's currently strong negotiating position (by virtue of its strong market position) could be threatened.

Market Share of Competitors

CareFirst's Top Three Competitors Market Share Change, 1995-2000
[market share in CareFirst's market area]



Source: CareFirst Data, Accenture Analysis

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Should CareFirst choose to pursue this course of action, CareFirst's constituents could benefit significantly.

Benefits could manifest in three ways:

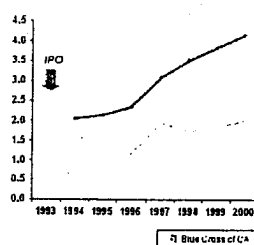
1. Lower premiums due to the potential for greater operating efficiencies,
2. Better service due to enhanced flexibility to invest in new technologies, and
3. Direct funding to meet a variety of health needs by virtue of the formation of substantial Public Benefit Obligation foundations.

To examine the potential impact on constituents, we examined the experiences of two other markets where similar changes occurred. Specifically, we examined the California market where in 1993 Blue Cross of California converted to a for-profit company, issued shares on the New York Stock Exchange, and subsequently acquired health plans in other states. We also examined the Connecticut market where the local non-profit Blue Cross Blue Shield plan was acquired by the larger mutual plan Anthem Blue Cross Blue Shield in 1997. For each market, we examined the financial and competitive performance of the health plans before and after the change. We also interviewed health plan members, employers, brokers, doctors, hospitals, regulators, and foundation leaders in each state and surveyed members of Blue Cross of California.

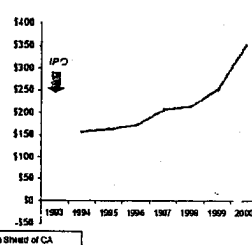
In both case studies, the transformed Blue-branded plans improved their performance and outperformed the competition after their respective transactions. California is a particularly interesting case because it is home to two Blue-branded health plans: Blue Shield of California and Blue Cross of California (WellPoint). Blue Shield remains private and not-for-profit. Blue Cross, as mentioned previously, converted to for-profit and went public. As measured by membership, the plans were close to the same size prior to Blue Cross' change. Since the change, Blue Cross' performance improved significantly relative to Blue Shield's performance.

Blue Cross of CA Compared with Blue Shield of CA

Membership - California
(in Millions)



Net Income - California
(in Millions)



Source: InterStudy, The National HMO Financial Database, 1994-2000. Data pulled from slide Department of Internal Affairs, Blue Cross membership source includes 625,000 members acquired through Great Health Plan acquisition.

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Anthem Blue Cross Blue Shield Connecticut also has experienced strong performance since its merger with Anthem:

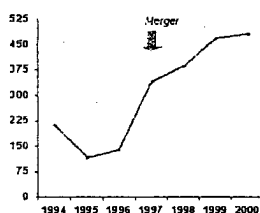
- In 1994, there were 13 health plans serving the CT market, with five plans holding greater than 10% market share. BCBS of CT led with a share of 25%. By 2000 only eight plans were still operating, Anthem BCBS CT had grown its market share to 32%, sharing the lead with HealthNet, which also captured 32%.
- Since 1997, Anthem Connecticut's administrative cost ratio (total administrative costs related to

providing health coverage divided by total premium revenues) decreased from 21% to 13%.

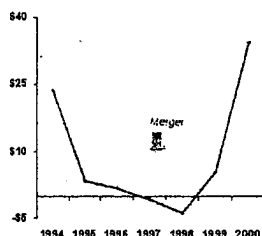
- The plan's net income improved from a net loss of \$5 million in 1997 to a net gain of over \$35 million in 2000.

Anthem/BCBS of CT Performance Indicators

Membership - Anthem BCBS Connecticut
(in millions of members)



Net Income - Anthem BCBS Connecticut
(in millions)



Source: The Industry Competitive Edge 1999 Industry Report 1 & 11, April 1999 & April 2001

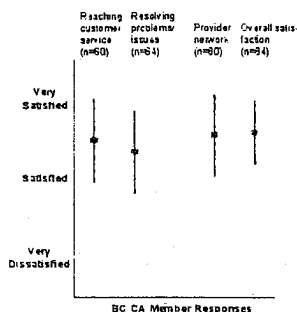
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Satisfying Constituents

- *Members and employers* who participated in our research reported, on average, that they maintain access to health coverage at competitive premiums and generally appear to perceive their service levels to be at or above the levels they experienced prior to the change. Some members and employers were not aware that a change had taken place. Members and employers in both markets appeared to still very much trust the Blue Cross and Blue Shield brand name.

Blue Cross of California Member Survey Responses

Current Level of Customer Satisfaction

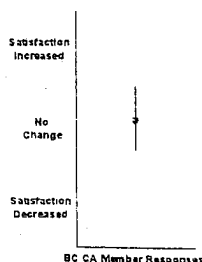


The dot represents the average and the lines represent the range of + and - 1 standard deviation

Source: Accenture survey, 1/02/01

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How Customer Satisfaction Has Changed Over Last 5 Years (n= 60)



The health plans believe their premium rate increases to members have become more predictable as a result of their respective transactions. In both cases, the plans reported that the increased emphasis on fiscal discipline caused them to become better at predicting and managing their costs, and as a result, their premiums. One executive at Anthem remarked, "Five years ago, rate changes were all over the place – sometimes high, sometimes low; now that we have admin[istrative] costs more under control and a more disciplined approach, we can manage our rates against healthcare cost trends more effectively." A health insurance broker in Connecticut stated that, "Yes, the prices have risen, but Anthem's have been lower, and more predictable."

Premium predictability is very important to employers, especially small employers, whose health care costs comprise a significant portion of their total employee benefit costs. Wide swings in premiums (e.g., very large increases in one year followed by a small increase in the next year) make it very difficult for them to plan and successfully manage their businesses. So, premium increase predictability is an important benefit to them. Standings for preventive care, service and satisfaction for the Blue-branded plans we analyzed remain at or near the top of the list. In addition to the significant charitable work driven by the Public Benefit Obligation foundations (described below), the converted Blue Cross Blue Shield Plans continue to receive recognition and awards for their care of at-risk populations.

- *Hospitals and Doctors*
 - More Disciplined Contracting Process – Both health plans appeared to have improved their ability to translate market demands and their customers' needs into terms for their doctor and hospital contracts. In this regard, they have become more accountable to their customers (members and employers). They also believe this has caused them

to become more disciplined and businesslike in their negotiations with doctors and hospitals. According to the doctors and hospitals with whom we spoke, Anthem Blue Cross Blue Shield in Connecticut was perceived to "run a tighter ship" and Blue Cross of California was perceived to be "tough and aggressive" in its contracting.

Due to the way medical care and its financing has evolved, a tension has developed between doctors and health plans. The intensity of this tension varies from region to region and from situation to situation. In California, Blue Cross of California's relationship with doctors appears to have been strained. In Connecticut, Anthem Connecticut's relationship with doctors appears less strained. The situational variability suggests the nature of the doctor/health plan relationship may depend more on the local practices, policies, and perspectives of physicians and health plans than on health plan corporate form (i.e., non-profit or for-profit) or health plan scale.

- Service to Hospitals and Doctors – Based on our discussions with doctors and hospitals in the markets studied, the health plans' service to doctors and hospitals generally appears to be at or above the levels of their major competitors.

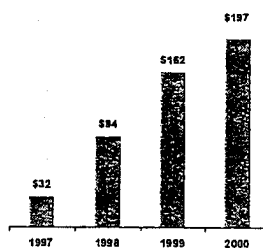
- *Brokers of Health Insurance* who were interviewed generally report they have seen the changed Blues plans become stronger in the marketplace, because not only can the groups buying insurance depend on the continued strength of the Blue Cross Blue Shield brand, but also rates are more predictable and service has improved. Many brokers stated that they also have experienced improved service themselves.

Community - The for-profit conversion of CareFirst would cause Public Benefit Obligation foundations to be established and funded by the proceeds of the

sale of CareFirst. Based on experience in other states, the combined funding for these foundations would likely be substantial. The conversion of 12 other Blue Cross Blue Shield plans in the U.S. has led to the creation of foundations currently worth a total of \$6.2 billion. Foundation Boards provide the opportunity to use the funds for a variety of unmet health care needs for citizens and health care institutions of the region. Many foundations target funding to increase access to health care, as well as to enhance the quality of care in their regions. In California, one of two foundations, the California Endowment, distributed \$197 million in 2000. Examples of the causes supported include:

Example of Foundation Activity

California Endowment - Grant Allocations in 2000 (\$in Millions)



Source: California Endowment Press Releases and Annual Reports

Examples of Grants Awarded (FY2000)

Access OPCA Ventures	\$5MM
• To provide access to affordable and culturally competent primary and preventive health care clinics to low-income and medically underserved populations	
Community Health Group Kaiser, Sharp Health	\$1.6MM
• To decrease the number of uninsured children and families in CA by providing subsidized coverage for children not eligible for existing programs due to immigration status	
Health & Well-being CA Dental Association Research Fund	\$5MM
• To support the efforts to improve the oral health of residents in 13 urban and rural sites through the installation of their water systems	
Multicultural Health Alameda Health Consortium	\$2MM
• To develop and test a community clinic based approach for reducing ethnic disparities in health status	

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Other examples of foundation activity include:

- Earlier this year, the California HealthCare Foundation granted \$2.5 million over two years to subsidize health insurance through the state's Managed Risk Medical Insurance Program for Californians who cannot obtain coverage in the individual health insurance market.
- A Foundation for a Healthy Kentucky gave \$1 million to the University of Kentucky to endow a chair for rural health, and \$1 million to the University of Louisville to endow a chair for urban health.

- The Caring for Colorado Foundation awarded \$1.4 million in grants to 21 urban and rural community healthcare projects in August 2001. These grants range from human services and emergency facilities in Conifer, to a hospital in Durango, to the purchase of a mobile health van for migrant farm workers and the homeless in Weld County, to technology for a clinic serving low-income, Latino families in Denver.
- The Commonwealth Health Research Fund recently announced more than \$825,000 in competitive grants to 13 medical and health researchers at public and private colleges across Virginia.
- The Anthem Foundation of Ohio provided \$250,000 in funding to establish a new community dental clinic for low-income families.

According to the articles announcing the WellPoint – RightCHOICE merger, the transaction created nearly \$900 million in value for the Missouri Foundation for Health, a dramatic increase in the funding for that state's health access and quality improvement programs.

The power of these foundations rests not just with their size, but also with the fact that they are singularly focused on pursuing their health care mission. To maintain federal tax-exempt status, they are required to spend a certain amount of their assets each year on activities related to their mission. In most instances, this results in a foundation granting at least 5% of its holdings towards that mission annually. We are not aware of any non-profit health plan able to spend as

much of its assets on such community causes, due to the intense competitiveness of the health insurance industry. As noted by David Pockell, former CEO of Kaiser Permanente's Northern California region, one of the largest non-profit health plans and now the Director of Programs for the California Health Care Foundation: "Tax-exempt organizations in health care struggle to balance the demands of a competitive marketplace with providing social value. With for-profit plans that have converted from not-for-profit status, it is sort of like the separation of church and state. Rather than trying to thrive as a business and also satisfy the level of social mission expected of a non-profit, converted plans focus more singularly on running a business, while most of the social mission is fulfilled by the resulting foundation. The 'for-profit and foundation' structure is one way to clarify the mission of each entity."

Given national and local trends regarding increased costs, required investments and competitive pressures, now appears to be a good time for CareFirst to continue to pursue increased scale through merging with another plan and accessing public equity markets. This approach could enhance CareFirst's ability to thrive so it can continue to serve and satisfy its constituents' needs over the longer term, and could benefit the communities in which CareFirst conducts business.

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November 16, 2001